AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2023

OFFERED BY M__. _____

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Asthmatic Schoolchildren's Treatment and Health Management Act of 2003''.

SEC. 2. FINDINGS.

The Congress finds the following:

(1) Asthma is a chronic condition requiring lifetime, ongoing medical intervention.

(2) In 1980, 6,700,000 Americans had asthma.

(3) In 2001, 20,300,000 Americans had asthma; 6,300,000 children under age 18 had asthma.

(4) The prevalence of asthma among African-American children was 40 percent greater than among Caucasian children, and more than 26 percent of all asthma deaths are in the African-American population.

(5) In 2000, there were 1,800,000 asthma-related visits to emergency departments (more than

728,000 of these involved children under 18 years of age).

(6) In 2000, there were 465,000 asthma-related hospitalizations (214,000 of these involved children under 18 years of age).

(7) In 2000, 4,487 people died from asthma, and of these 223 were children.

(8) Asthma is a common cause of missed school days, accounting for approximately 14,000,000 missed school days annually.

(9) Working parents of children with asthma lose an estimated $1,000,000,000 a year in productivity.

(10) At least 18 States have legislation protecting the rights of children to carry and self-administer asthma metered-dose inhalers, and at least 8 States expand this protection to epinephrine auto-injectors.

(11) Guidelines do not necessarily protect the rights of children in every school—tragic refusals of schools to permit students to carry their inhalers and auto-injectable epinephrine have occurred, some resulting in death and spawning litigation.

(12) Schools that restrict or revoke the rights of children to carry such inhalers and auto-injectable

epinephrine put themselves and students with asthma and severe allergic reactions, including anaphylaxis, at risk of death. Such schools also put other students at risk of witnessing a potentially life-threatening asthma attack.

(13) School district medication policies must be developed with the safety of all students in mind. Easy access to and correct use of asthma inhalers are necessary to avoid serious respiratory complications secondary to acute exacerbation and to improve the quality of life of students with asthma.

(14) No school should interfere with the patient-physician relationship.

(15) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within minutes. Anaphylaxis occurs in some asthma patients. According to the American Academy of Allergy, Asthma, and Immunology, people who have experienced symptoms of anaphylaxis previously are at risk for subsequent reactions and should carry an epinephrine auto-injector with them at all times, if prescribed.

(16) Because asthma is a condition that often arises from allergies, it is critical to include anaphylaxis in asthma treatment. Specifically, the res-

piratory problems that arise during an asthma attack usually occur because of a reaction to certain allergens, including dust, pollen, molds, and specific foods.

(17) An increasing number of students and school staff have life-threatening allergies. Exposure to the affecting allergen can trigger anaphylaxis. Anaphylaxis requires prompt medical intervention with an injection of epinephrine.

(18) Avoidance, early recognition, and prompt treatment are essential to the management of life-threatening allergies. There are students and school staff who have known life-threatening allergies, and those who have not been identified. Prompt intervention with epinephrine is vital to saving lives.

SEC. 3. PREFERENCE FOR STATES THAT ALLOW STUDENTS TO SELF-ADMINISTER MEDICATION TO TREAT ASTHMA AND ANAPHYLAXIS.

Section 399L of the Public Health Service Act (42 U.S.C. 280g) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following:

''(d) PREFERENCE FOR STATES THAT ALLOW STUDENTS TO SELF-ADMINISTER MEDICATION TO TREAT ASTHMA AND ANAPHYLAXIS.—

''(1) PREFERENCE.—The Secretary, in making any grant under this section or any other grant that is asthma-related (as determined by the Secretary) to a State, shall give preference to any State that satisfies the following:

''(A) IN GENERAL.—The State must require that each elementary school and secondary school (whether public or nonpublic) in that State will grant to any student in the school an authorization for the self-administration of medication to treat that student's asthma or anaphylaxis, if—

''(i) a health care practitioner prescribed the medication for use by the student during school hours and instructed the student in the correct and responsible use of the medication;

''(ii) the student has demonstrated to the health care practitioner (or such practitioner's designee) and the school nurse (if available) the skill level necessary to use the medication and any device that is nec-

essary to administer such medication as prescribed;

''(iii) the health care practitioner formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours; and

''(iv) the student's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan formulated under clause (iii).

''(B) SCOPE.—An authorization granted under paragraph (1) must allow the student involved to possess and use his or her medication—

''(i) while in school;

''(ii) while at a school-sponsored activity;

''(iii) during normal before-school and after-school activities, such as before-school or after-school care on school-operated property; and

''(iv) in transit to or from school or school-sponsored activities.

''(C) DURATION OF AUTHORIZATION.—An authorization granted under paragraph (1)—

''(i) must be effective only for the school year for which it is granted; and

''(ii) must be renewed by the parent or guardian each subsequent school year in accordance with this subsection.

''(D) BACKUP MEDICATION.—The State must require that backup medication, if provided by a student's parent or guardian, be kept at a student's school in a location easily accessible to the student in the event of an asthma or anaphylaxis emergency.

''(E) MAINTENANCE OF INFORMATION.—The State must require that information described in subparagraphs (A)(iii) and (A)(iv) be kept on file at the student's school in a location easily accessible in the event of an asthma or anaphylaxis emergency.

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection creates a cause of action or in any other way increases or diminishes the liability of any person under any other law.

''(3) DEFINITIONS.—For purposes of this subsection:

"(A) The terms 'elementary school' and 'secondary school' have the meaning given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965.

"(B) The term 'health care practitioner' means a person authorized under law to prescribe drugs subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act.

"(C) The term 'medication' means a drug as that term is defined in section 201 of the Federal Food, Drug, and Cosmetic Act and includes inhaled bronchodilators and autoinjectable epinephrine.

"(E) The term 'self-administration' means a student's discretionary use of his or her prescribed asthma or anaphylaxis medication, pursuant to a prescription or written direction from a health care practitioner.".

SEC. 5. SENSE OF CONGRESS REGARDING CDC'S STRATEGIES FOR ADDRESSING ASTHMA WITHIN A COORDINATED SCHOOL HEALTH PROGRAM.

(a) FINDINGS.—The Congress finds as follows:

(1) Possession and administration of medication is only 1 component of asthma and anaphylaxis management.

(2) The Centers for Disease Control and Prevention has identified 6 strategies for addressing asthma within a coordinated school health program. These strategies consist of the following:

(A) Establishing management and support systems for asthma-friendly schools.

(B) Providing appropriate school health and mental health services for students with asthma.

(C) Providing asthma education and awareness programs for students, school staff, parents, and guardians.

(D) Providing a safe and healthy school environment to reduce asthma triggers.

(E) Providing safe, enjoyable physical education and activity opportunities for students with asthma.

(F) Coordinating school, family, and community efforts to better manage asthma symptoms and reduce school absences among students with asthma.

(3) Providing appropriate school health and mental health services for students with asthma includes the following:

(A) Obtaining a written asthma action plan for all students with asthma, which plan—

(i) should be developed by a primary care provider and provided by parents;

(ii) should include individualized emergency protocol, medications, peak flow monitoring, environmental triggers, and emergency contact information; and

(iii) should be effective only for the school year for which the plan is granted and must be renewed by the physician and parents or guardian of the student each subsequent school year.

(B) Sharing the plan with appropriate faculty and staff in accordance with guidelines under section 444 of the General Education Provisions Act (20 U.S.C. 1232g; commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') or with parental permission.

(C) Ensuring that—

(i) at all times students have options for immediate access to medications, as prescribed by a physician and approved by parents; and

(ii) specific options, such as allowing students to self-carry and self-administer medications, are determined on a case-by-case basis with input from the physician, parent, and school.

(D) Using standard emergency protocols for students in respiratory distress if they do not have their own asthma action plan.

(E) Ensuring that case management is provided for students with frequent school absences, school health office visits, emergency department visits, or hospitalizations due to asthma.

(F) Providing a full-time registered nurse all day, every day for each school.

(G) Ensuring access to a consulting physician for each school.

(H) Referring students without a primary care provider to child health insurance programs and providers.

(I) Providing and coordinating school-based counseling, psychological, and social services for students with asthma, as appropriate.

(J) Coordinating with community services.

(b) EXPRESSION OF SUPPORT.—The Congress supports the goals and ideals of the strategies identified by the Centers for Disease Control and Prevention for addressing asthma within a coordinated school health program.